Department of LABOR AND INDUSTRIES

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PROVIDER BULLETIN

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THIS ISSUE

Corrections & Updates to the Medical Aid Rules & Fee Schedules; FAQs About Provider Publications

TO:

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Self-Insured Employers

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Purpose

This bulletin contains corrections and updates to the July 1, 2002 *Medical Aid Rules and Fee Schedules* (Fee Schedule) and answers to frequently asked questions about provider publications. The corrections and updates are effective for dates of service on or after July 1, 2002 unless otherwise noted.

Table of Contents

Correction to the Medical Aid Rules Section

WAC 296-23A-00220

Page 106: The correct title for WAC 296-23A-0220 is "How does the department pay for hospital outpatient services?"

Corrections to the Professional Services Payment Policies

Surgery Services

Miscellaneous: Closure of Enterostomy

Page 159: This section titled "Closure of Enterostomy" should be changed to:

"Closures of enterostomy (CPT® codes 44625 and 44626) are not payable with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy (CPT® code 44139). CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626."

Physical Medicine Services

Non-Board Certified/ Qualified Physical Medicine Providers

Page 168: The third bulleted item in this section references the wrong WAC. The correct reference is WAC 296-21-290.

Chiropractic Services: Consultations

Page 173: This section states that the department annually publishes a Provider Bulletin about chiropractic consultations; the bulletin is published every other year.

Other Medicine Services

Ventilator Management

Page 180: The E/M code range referenced in the ventilator management section is incorrect. The correct code range is CPT® 99201-99499.

The first sentence in the ventilator management section should be changed to: "No payment will be made for ventilator management services (CPT® codes 94656, 94657, 94660 and 94662) when an E/M service (CPT® codes 99201-99499) is reported on the same day by the same provider."

Medication Administration: Immunizations

Page 180: The published maximum daily fee for CPT® add-on code 90472 is incorrect. The correct maximum daily fee is $5.56.

Medication Administration: Therapeutic or Diagnostic Injections

Page 182: This section incorrectly instructs providers to bill for dry needling of trigger points using CPT® 20550. Dry needling of trigger points should be billed with CPT® code 20552 or 20553.

Medication Administration: Injectable Medications

Page 182: The published rates for hyaluronic acid for osteoarthritis of the knee are incorrect. The correct maximum fees are:
3020A - $226.20
3040B - $326.42

Other Services

Vocational Services

Page 201: The published hourly rates for vocational interns and forensic evaluators are incorrect. The correct hourly rates are:

- $ 64.30 per hour for vocational interns
- $ 90.80 per hour for forensic evaluators

The published maximum fee for 0881V is incorrect. The correct maximum fee is $9.08.

Clarification to the Facility Services Payment Policies

Hospital Payment Policies

Hospital Outpatient Payment Information

Page 211: The note regarding HCPCS code Q0081 was unclear. This note is not limited to claimants receiving services from the Crime Victims Compensation Program. Q0081 is also covered for hospital services provided to injured workers.

Corrections and Updates to the Professional Services Fee Schedule

Corrections Effective July 1, 2002

The maximum fees for the following codes should be updated according to the following table for services provided on or after July 1, 2002.

CPT®/ HCPCS CODE	ABBREVIATED DESCRIPTION	DOLLAR VALUE NON-FACILITY SETTING	DOLLAR VALUE FACILITY SETTING	FSI
75952-26	Endovasc repair abdom aorta	$ 308.62	$ 308.62	R
90709	Rubella & Mumps vaccine, sc	Not Covered	Not Covered	X
90725	Cholera vaccine, injectable	Not Covered	Not Covered	X
93784	Ambulatory BP monitoring	$ 60.11	$ 60.11	R
93786	Ambulatory BP recording	$ 47.98	$ 47.98	R
93790	Review/report BP recording	$ 12.63	$ 12.63	R
G0248	Demonstrate use home INR	$ 156.58	$ 156.58	R
G0249	Provide test material, equipm	$ 167.69	$ 167.69	R
G0250	MD review interpret of test	$ 12.63	$ 12.63	R
J0190	Inj biperiden lactate/5 mg	Not Covered	Not Covered	X
J1890	Cephalothin sodium injection	Not Covered	Not Covered	X
J3364	Urokinase 5000 IU injection	Not Covered	Not Covered	X
J7681	Terbutaline so4 inh sol u d	Not Covered	Not Covered	X
J7682	Tobramycin inhalation sol	Not Covered	Not Covered	X
Q0081	Infusion ther other than che	By Report/ Hospitals Only	By Report/ Hospitals Only	N
Q0144	Azithromycin dihydrate, oral	Not Covered	Not Covered	X

Additional Codes Effective July 1, 2002

The following codes were inadvertently excluded from the July 1, 2002 *Medical Aid Rules and Fee Schedules*.

HCPCS CODE	ABBREVIATED DESCRIPTION	DOLLAR VALUE NON-FACILITY SETTING	DOLLAR VALUE FACILITY SETTING	FSI
G0252-26	PET imaging	Not Covered	Not Covered	X
G0252-TC	PET imaging	Not Covered	Not Covered	X
G0253-26	PET imaging	Not Covered	Not Covered	X
G0253-TC	PET imaging	Not Covered	Not Covered	X
G0254-26	PET imaging	Not Covered	Not Covered	X
G0254-TC	PET imaging	Not Covered	Not Covered	X

New HCPCS Codes Effective October 1, 2002

The following procedure codes are valid for services provided on or after October 1, 2002.

HCPCS CODE	ABBREVIATED DESCRIPTION	DOLLAR VALUE		FSI
		NON-FACILITY SETTING	FACILITY SETTING	
G0255	Sensory nerve conduct test	Not Covered	Not Covered	X
G0255-26	Sensory nerve conduct test	Not Covered	Not Covered	X
G0255-TC	Sensory nerve conduct test	Not Covered	Not Covered	X
K0556	Addn to lower extremity above/below knee	By Report	By Report	N
K0557	Addn to lower extremity above/below knee	By Report	By Report	N
K0558	Addn to lower extremity above/below knee	By Report	By Report	N
K0559	Addn to lower extremity above/below knee	By Report	By Report	N
S0104	Zidovudine, oral, 100 mg	Not Covered	Not Covered	X
S0135	Injection, pegfilgrastim, 6 mg	Not Covered	Not Covered	X
S0201	Partial hospitalization services	Not Covered	Not Covered	X
S0207	Paramedic intercept	Not Covered	Not Covered	X
S0315	Disease management program; initial	Not Covered	Not Covered	X
S0316	Disease management program; follow-up	Not Covered	Not Covered	X
S0320	Telephone calls by RN to disease man	Not Covered	Not Covered	X
S1040	Cranial removal orthosis	Not Covered	Not Covered	X
S2262	Abortion for maternal indication, 25 weeks	Not Covered	Not Covered	X
S2265	Abortion for fetal indication, 25-28 weeks	Not Covered	Not Covered	X
S2266	Abortion for fetal indication, 29-31 weeks	Not Covered	Not Covered	X
S2267	Abortion for fetal indication, 32 weeks or	Not Covered	Not Covered	X
S3655	Antisperm antibodies test (immunobead)	Not Covered	Not Covered	X
S8002	Supply of diagnostic radioimmunopharmac	Not Covered	Not Covered	X
S8003	Supply of therapeutic radioimmunopharm	Not Covered	Not Covered	X
S8004	Radioimmunopharmaceutical localization of	Not Covered	Not Covered	X
S9150	Evaluation by ocularist	Not Covered	Not Covered	X
T1022	Contracted services per day	Not Covered	Not Covered	X
T1023	Program intake assessment	Not Covered	Not Covered	X
T1024	Team evaluation & management	Not Covered	Not Covered	X
T1025	Ped compr care pkg, per diem	Not Covered	Not Covered	X
T1026	Ped compr care pkg, per hour	Not Covered	Not Covered	X
T1027	Family training & counseling	Not Covered	Not Covered	X
T1028	Home environment assessment	Not Covered	Not Covered	X
T1500	Reusable diaper/pant	Not Covered	Not Covered	X
T1501	Reusable underpad	Not Covered	Not Covered	X
T1999	NOC retail supplies/supplies	Not Covered	Not Covered	X
T2007	Non-emer transport wait time	Not Covered	Not Covered	X

New CPT® Category III Codes Effective October 1, 2002

The following CPT® category III procedure codes are valid for services provided on or after October 1, 2002.

CPT® CODE	ABBREVIATED DESCRIPTION	DOLLAR VALUE		FSI
		NON-FACILITY SETTING	FACILITY SETTING	
0027T	Endoscopic lysis of epidural adhesions	By Report	By Report	N
0029T	Treatment(s) for incontinence	By Report	By Report	N
0030T	Antiprothrombin antibody	Not Covered	Not Covered	X
0031T	Speculoscopy	Not Covered	Not Covered	X
0032T	Speculoscopy, with directed sampling	Not Covered	Not Covered	X
0033T	Endovascular repair of aortic aneurysm	By Report	By Report	N
0034T	Endovascular repair of aortic aneurysm	By Report	By Report	N
0035T	Placement of extension prosthesis	By Report	By Report	N
0036T	Each addl extension prosth	By Report	By Report	N
0037T	Subclavian to carotid artery transposition	By Report	By Report	N
0038T	Endovasc repair, radiological sprvsn and intrprt	By Report	By Report	N
0039T	Endovasc repair, radiological sprvsn and intrprt	By Report	By Report	N
0040T	Ext prosthesis, radiological sprvsn and intrprt	By Report	By Report	N
0041T	Urinalysis infectious agent detection	By Report	By Report	N
0042T	Cerebral perfusion analysis	By Report	By Report	N
0043T	Carbon monoxide, expired gas analysis	By Report	By Report	N
0044T	Whole body integumentary photography	Not Covered	Not Covered	X

Codes End Dated December 31, 2002

The following procedure codes will be end dated December 31, 2002. These procedure codes will not be valid for services provided on or after January 1, 2003.

HCPCS CODE	ABBREVIATED DESCRIPTION	NOTES
L5660	Sock insrt syme silicone gel	Replaced by K0556-K0559
L5662	Socket insert bk silicone gel	Replaced by K0556-K0559
L5663	Sock knee disartic silicone	Replaced by K0556-K0559
L5664	Socket insert ak silicone ge	Replaced by K0556-K0559
S9543	Administration of medication	
S9105	Evaluation by ocularist	Correct code is S9150

Changes to Bilateral Surgery Indicators

The bilateral surgery indicator is being updated for the following procedure codes. Effective for dates of service on or after July 1, 2002 the bilateral surgery indicator for these procedure codes is "1" (Payment adjustment for bilateral procedures applies. Modifier –50 is valid).

CPT® CODE	ABBREVIATED DESCRIPTION	BSI
20526	Ther injection carpal tunnel	1
24300	Manipulate elbow w/anesth	1
24332	Tenolysis, triceps	1
25259	Manipulate wrist w/anesthes	1
25275	Repair forearm tendon sheath	1
25430	Vasc graft into carpal bone	1
25651	Pin ulnar styloid fracture	1
25652	Treat fracture ulnar styloid	1
25671	Pin radioulnar dislocation	1
26340	Manipulate finger w/anesth	1
29824	Shoulder arthroscopy/surgery	1
36002	Pseudoaneurysm injection trt	1
36533	Insertion of access device	1
36534	Revision of access device	1
36535	Removal of access device	1
36820	Av fusion/forearm vein	1
37208	Transcatheter stent add-on	1
38220	Bone marrow aspiration	1
38221	Bone marrow biopsy	1
61862	Implant neurostimul, subcort	1

CPT® CODE	ABBREVIATED DESCRIPTION	BSI
61880	Revise/remove neuroelectrode	1
61885	Implant neurostim one array	1
61888	Revise/remove neuroreceiver	1
63043	Laminotomy, addl cervical	1
63044	Laminotomy, addl lumbar	1
64821	Remove sympathetic nerves	1
64822	Remove sympathetic nerves	1
64823	Remove sympathetic nerves	1
69300	Revise external ear	1
0005T	Perc cath stent/brain cv art	1
0006T	Perc cath stent/brain cv art	1
0007T	Perc cath stent/brain cv art	1
0012T	Osteochondral knee autograft	1
0013T	Osteochondral knee allograft	1
0014T	Meniscal transplant, knee	1
0016T	Thermotx choroid vasc lesion	1
0017T	Photocoagulat macular drusen	1
0020T	Extracorp shock wave tx, ft	1

Updates to the Ambulatory Surgery Center Fee Schedule

ASC Fee Schedule Updates Effective January 1, 2002

The following modifiers are approved for use by Ambulatory Surgery Centers for dates of service on or after January 1, 2002.

CPT® MODIFIER	MODIFIER DESCRIPTION
58	Related procedure or service by same physician during postop period
78	Return to OR for related procedure during postop period
79	Unrelated procedure or service by same physician during postop period

Ambulatory surgery center facility payments are allowed for the following procedure codes for dates of service on or after January 1, 2002.

HCPCS CODE	ABBREVIATED DESCRIPTION	Group	Rate
V2623	Plastic eye prosthesis custom	NG	BR
V2629	Prosthetic eye other type	NG	BR

ASC Fee Schedule Updates Effective April 1, 2002

Ambulatory surgery center facility payments are allowed for the following procedure codes for dates of service on or after April 1, 2002. Refer to a CPT® book for code descriptions. These procedure codes do not belong to an ASC group and are payable on a "by report" basis.

CPT® Code	CPT® Code	CPT® Code	CPT® Code	CPT® Code	CPT® Code	CPT® Code	CPT® Code	CPT® Code	CPT® Code
15860	24220	25651	35685	36140	36410	42550	49427	59425	65760
19030	24300	25652	35686	36145	36415	43752	50394	59426	65765
19295	24332	26340	36000	36160	36481	44203	52347	59430	65767
20501	24343	27095	36002	36200	36500	44204	53448	59510	67225
20526	24344	27370	36005	36215	36540	44205	53670	59515	68850
20551	24345	27648	36010	36216	36600	45136	53853	59610	69401
20552	24346	29086	36011	36217	36620	46600	54230	59614	
20553	25001	29799	36012	36218	36625	47500	54411	59618	
20974	25246	31708	36013	36245	38200	47505	54417	59622	
20979	25259	33967	36014	36246	38220	48160	55300	64550	
20999	25394	33979	36015	36247	38221	48550	58340	64821	
21116	25430	33980	36100	36248	38792	48554	59001	64822	
23350	25431	35647	36120	36299	38794	49424	59051	64823	

ASC Fee Schedule Updates Effective July 1, 2002

Ambulatory surgery center facility payments are allowed for the following procedure codes for dates of service on or after July 1, 2002.

CPT® CODE	ABBREVIATED DESCRIPTION	GROUP	RATE
72240	Myelography cervical suprv and intrpt	NG	$238.91
72255	Myelography thoracic suprv and intrpt	NG	$217.19
72265	Myelography lumbosacral suprv and intrpt	NG	$204.57
72270	Myelography entire spine suprv & intrpt	NG	$306.60
72275	Epiduropgraphy,radiological superv&inter	NG	$108.60
72285	Diskography cervical supervision and int	NG	$420.75
72295	Diskography lumbar supervision and inter	NG	$394.48
75705	Angiography spinal selct sup & int	NG	$632.39
76000	Fluoroscopy,sep proc,up to 1 hr, othr th	NG	$65.66
76003	Fluorscpc localiz fr needle biop/aspir	NG	$65.66
76360	Comput tomograph fr needle biopsy s&i	NG	$414.18
76942	Ultrasonic guidance needle biopsy s	NG	$76.78

Corrections and Updates to the Appendices

Appendix D: Non-Covered Codes and Modifiers

Pages 697-709: The following codes should be added to the appendix of non-covered codes:

CPT®/ HCPCS CODE	ABBREVIATED DESCRIPTION
90709	Rubella & mumps vaccine, sc
90725	Cholera vaccine, injectable
J0190	Inj biperiden lactate/5 mg
J1890	Cephalothin sodium injection
J3364	Urokinase 5000 IU injection
J7681	Terbutaline so4 inh sol u d
J7682	Tobramycin inhalation sol
Q0144	Azithromycin dihydrate, oral

Appendix G: Outpatient Drug Formulary

Pages 715-726: The following Therapeutic Class Codes should be added to the outpatient drug formulary.

Status	TCC	Description	Representative Drug
PA	B1C	PULMONARY ANTIHYPERTENSIVES, PROSTAGLANDIN TYPE	FLOLAN
D	C1K	CARDIOPLEGIC SOLUTIONS	PLEGISOL
D	D4O	GASTROINTESTINAL ULTRASOUND IMAGE ENHANCING	SONORX
A	D4Q	DIGESTIVE AGENTS, OTHER	IMUZYME
D	D6E	IRRITABLE BOWEL SYNDROME AGENTS, 5-HT4 PARTIAL AGONIST	ZELNORM
D	G9B	CONTRACEPTIVES,INTRAVAGINAL, SYSTEMIC	NUVARING
A	H7O	ANTIPSYCHOTIC, DOPAMINE ANTAGONIST, BUTYROPHEN	HALOPERIDOL
A	H7P	ANTIPSYCHOTIC, DOPAMINE ANTAGONIST, THIOXANTHE	THIOTHIXENE
A	H7R	ANTIPSYCHOTIC, DOPAMINE ANTAGONIST, DIPHENYLBU	ORAP
A	H7S	ANTIPSYCHOTIC, DOPAMINE AND SEROTONIN ANTAGONI	MOBAN
A	H7T	ANTIPSYCHOTIC, ATYPICAL DOPAMINE AND SEROTONIN	RISPERDAL
A	H7U	ANTIPSYCHOTIC, DOPAMINE AND SEROTONIN ANTAGONI	LOXAPINE
D	H7W	ANTI-NARCOLEPSY/ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT	XYREM
A	J5G	BETA-ADRENERGICS AND GLUCOCORTICOIDS COMBINA	ADVAIR DISKUS
PA	Q3E	CHRONIC INFLM COLON DX 5 - AMINOSALICYLATES	ROWASA
PA	V1Q	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITOR	GLEEVEC
PA	V1T	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERM)	FASLODEX
A	W1W	CEPHALOSPORINS-1ST GENERATION	CEPHALEXIN
A	W1X	CEPHALOSPORINS-2ND GENERATION	CEFUROXIME
A	W1Y	CEPHALOSPORINS-3RD GENERATION	ROCEPHIN
A	W1Z	CEPHALOSPORINS-4TH GENERATION	MAXIPIME

New Appendix- Appendix H: Documentation Requirements

The July 2002 Fee Schedule incorporated the department's documentation requirements into the pertinent payment policy sections throughout the Fee Schedule. Based on customer feedback we have reinstated an appendix outlining the department's documentation requirements.

APPENDIX H
DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements published by the American Medical Association in the Physicians' Current Procedural Terminology book, the department or Self-Insurer has additional reporting and documentation requirements. These requirements are described below. The department's Report of Accident or the Self-Insurer's Physician's Initial Report are payable separately. No additional amount is payable for reports required to support billing.

Service	Code(s)	Requirements
Case Management and Telephone Calls	CPT® 99361-99373	Documentation in the medical record should include: the date, the participants and their titles, the length of the call or visit, the nature of the call or visit, and any medical decisions made during the call.
Chiropractic Care Visit	Local 2050A & 2051A	Office/chart notes
	Local 2052A	Report substantiating need for level and type of service
Consultation	CPT® 99241-99275	Narrative report due to the insurer in 15 days
Critical Care	CPT® 99291 & 99292	Narrative report
Emergency Room	CPT® 99281 & 99282	Report of accident and notes in the hospital medical record or report
	CPT® 99283-99285	Report of accident and report
Hospital	CPT® 99221-99223	Report of accident and report
	CPT® 99231-99238	Narrative report
Nursing Facility	CPT® 99301-99303	Narrative report
	CPT® 99311	Office notes (or chart notes)
	CPT® 99312 & 99313	Narrative report
Office Visit	CPT® 99201 & 99202	Report of accident and office notes (or chart notes) due to the insurer in 5 days
	CPT® 99203-99205	Report of accident and report due to the insurer in 5 days
	CPT® 99211 & 99212	Office notes (or chart notes) in SOAPER format
	CPT® 99213-99215	Narrative report
Prolonged Services	CPT® 99354-99359	Narrative report
Psychiatric Services	CPT® 90804-90853	Narrative report
Standby	CPT® 99360	Narrative report
Miscellaneous	CPT® 99288 & 99499	Narrative report

Answers to Frequently Asked Questions About Department Publications

How can I access the Fee Schedule or Provider Bulletins on the Internet?

To access the Fee Schedule on the Internet:

1. Visit the department's "Provider Information" home page at: www.lni.wa.gov/hsa
2. Select "Fee Schedules" under the heading "Medical Aid Rules and Fee Schedules."
3. You must read and agree to abide by the terms of the American Medical Association copyright agreement to access the Fee Schedule.
4. After reading the copyright statement, select "I Agree" to be linked to the Medical Aid Rules and Fee Schedules home page.

To access Provider Bulletins on the Internet:

1. Visit the department's "Provider Information" home page at: www.lni.wa.gov/hsa
2. Select "Provider Bulletins and Updates" under the heading "Provider Bulletins."
3. Select "Provider Bulletins" to be linked to the American Medical Association copyright notice.
4. You must read and agree to abide by the terms of the American Medical Association copyright agreement to access Provider Bulletins or Provider Updates.
5. After reading the copyright statement, select "I Agree" to be linked to the Provider Bulletins & Updates home page.

How can I order a paper copy of the Fee Schedule?

You can request a copy of the Fee Schedule by contacting the Provider Hotline at 1-800-848-0811 or by sending a Medical Forms Request Card to the department's warehouse. The Medical Forms Request Card is available on the Internet at http://www.lni.wa.gov/forms/Tables/Providers.htm. The form to request is F245-094-000 "Med Aid Rules and Fee Schedules."

Why didn't I receive a Fee Schedule this year?

The *Medical Aid Rules and Fee Schedules* is published annually and mailed to providers with active accounts who have indicated that they want to receive the Fee Schedule.

If you are a health care or vocational services provider and you did not receive the July 1, 2002 *Medical Aid Rules and Fee Schedule*s, it may be because:

1. You did not have an active provider account at the time the Fee Schedules were mailed, or
2. Your provider account profile does not indicate that you want to receive the annual updates to the *Medical Aid Rules and Fee Schedules*, or
3. Your provider account profile indicates the wrong mailing address for receiving the *Medical Aid Rules and Fee Schedules*.

If you did not receive this year's Fee Schedule and want to receive future updates, you may need to update your provider account profile. You can update your account by contacting the Provider Accounts section at 360-902-5140 or the Provider Hotline at 1-800-848-0811.

How can I change how I receive the *Medical Aid Rules and Fee Schedules* or *Provider Bulletins* and *Provider Updates*?

If you are a Health Care or Vocational Services Provider

If you are a health care or vocational services provider, you can customize your provider account to indicate:

- How many Fee Schedules you need to receive on an annual basis (0 to 999)
- How many Provider Bulletins and Provider Updates you need to receive (0 to 999)
- Up to two addresses for department mailings
- The address at which you want to receive your Fee Schedules
- The address at which you want to receive your *Provider Bulletins* and *Provider Updates*

To update your account, contact the Provider Accounts section at 360-902-5140 or the Provider Hotline at 1-800-848-0811.

If you are Not a Provider

If you do not have a provider account and would like to receive the *Medical Aid Rules and Fee Schedules* or *Provider Bulletins and Updates*, you can be added to a mailing list to receive these publications.

To be added to the mailing list, send us a request including:

- your name,
- which publications you want to receive: the *Medical Aid Rules and Fee Schedules*, *Provider Bulletins and Updates*, or both publications,
- the address(es) where you'd like the publication(s) mailed, and
- a phone number and/or email address where we can reach you if we have questions.

Requests to be added to the Fee Schedule or Provider Bulletin mailing list can be emailed to poth235@lni.wa.gov or mailed to:

Labor and Industries
Health Services Analysis
Fee Schedule/Provider Bulletin Mailing List
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